NEW YORK STATE DEPARTMENT OF HEALTH **Encephalitis Initial Case Report Form**

PATIENT INFORMATION

Last name_____ First Name _____ MI __ County/Borough _____
Address _____City _____ Zipcode _____State____
Telephone -H (____)_____-_____ W (____)_____-_____ Date of Birth ____/____/____ Age_____
Occupation:_____ Race: White Black Am Indian/Alaskan Asian Other
Ethnicity: Hispanic Non-hispanic Unk Sex: Male Female Pregnant: Yes No Unknown

CLINICAL INFORMATION

Hospitalized? Yes No If yes, Hospital Name_____
Street Address_____ City_____ State_____ Zip _____
Medical record # _____Date of admission ____/____/____ Date of discharge/transfer ____/____/___

Date of first symptoms ____/____/____ Date of first *neurologic* symptoms ____/____/____
Current Diagnosis: encephalitis meningitis other_____

Fever (≥ 38°C or 100°F)	Yes	No	Unknown	Altered mental status	Yes	No	Unknown
Headache	Yes	No	Unknown	Stiff neck/Meningeal signs	Yes	No	Unknown
Seizures	Yes	No	Unknown	Muscle weakness	Yes	No	Unknown
Rash	Yes	No	Unknown	Muscle pain	Yes	No	Unknown
Other neurologic signs	Yes	No	Unknown	Joint pain	Yes	No	Unknown

Other symptoms (current or 1 month before onset)_____
Outcome Recovered Died Unknown If patient died, date of death ____/____/____

LABORATORY INFORMATION / TEST RESULTS

CSF (specify units) Date ____/____/____ Abnormal? Yes No Unknown
Glu _____ Prot _____ RBC _____ WBC _____ Diff: Segs% _____ Lymphs%_____
Gram stain _____ Bacterial Culture _____ Fungal / Parasitic tests _____
Viral test results (Culture/ Serology / PCR) _____
CBC (specify units) Date ____/____/____ WBC _____ Diff: Segs% _____ Lymphs% _____
MRI Date ____/____/____ Result_____
CT Date ____/____/____ Result_____
EMG Date ____/____/____ Result_____

ANTIVIRALTREATMENT Yes No Unk If yes, list below. **Date started:**
1. _____ _____
2._____ _____

RISK FACTOR INFORMATION (during **1 month** before onset) **Location** **Dates**

Travel outside country?	Yes	No	Unk	_____	_____
Travel outside New York State?	Yes	No	Unk	_____	_____
Travel outside county of residence?	Yes	No	Unk	_____	_____
				_____	_____

Animal or arthropod contact? Yes No Unk Specify: _____

REPORTED BY:

Last name _____First name _____Title (ICN, Resident, Attending) _____
Work address_____ City _____ State___ Zip Code _____
Telephone (____)_____-_____ Pager (____)_____-_____
Date of Report: ___/___/___

This form must be faxed to the Local Health Unit *and* a copy submitted with the laboratory specimen(s) to the NYSDOH Wadsworth Center Laboratory.

NEW YORK STATE DEPARTMENT OF HEALTH **Encephalitis Specimen Submission Form**

Date of Submission: ___/___/___ Initial** Repeat Specimen

IDENTIFYING PATIENT INFORMATION

Last name _____ First name _____MI _____
Date of Birth____/____/____ Age_____ County / Borough _____
Street Address: _____
City: _____ State____ Zipcode _____

If hospitalized, Hospital name_____ Medical record # _____
Street Address: _____
City _____ State _____ Zip Code _____

Date of first symptom: ____/____/____

Specimen No.	Type of Specimen: CSF, Serum, or Tissue (specify type)	Date of Collection	*For Health Department Use Only* Lab ID	Accession Number
1.				
2.				
3.				
4.				

REQUESTING PHYSICIAN

Last name _____First name _____
Work address_____
City _____ State_____ Zip Code _____
Telephone (____)_____-_____ Pager (____)_____-_____

To submit specimens for encephalitis testing:

1. **The local health department must be contacted prior to specimen submission.**
2. **This form** must be faxed to the local health department *AND* submitted along with the clinical specimens.**

Send Specimens to:

Dr. Cinnia Huang
Griffin Laboratory
New York State Department of Health
Route 155
Guilderland, NY 12084

****If this is an initial specimen submission, the Encephalitis/ Meningitis Initial Case Report Form must also be completed.**